Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH HILLS HOSPITAL
10030 N MACARTHUR BLVD STE 100
IRVING TX 75063-5083

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0516-01

MFDR Date Received
October 18, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorized with Humana Thereputic injections and medication for Pain. Pt. did not give Work Comp billing info initially. Please Review for medical Necessity."

Amount in Dispute: $32,967.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2011 to April 2, 2011	Outpatient Hospital Services	$32,967.00	$4,549.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent.
   - 19 – (197) Precertification/authorization/notification absent.

Issues

1. Was preauthorization required for the disputed services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied payment for the disputed services with reason codes 197 and 19 – "Precertification/authorization/notification absent." Per 28 Texas Administrative Code §134.600(c) "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." 28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted information finds documentation to support the occurrence of a medical emergency; therefore, preauthorization was not required. Consequently, the insurance carrier's denial reason is not supported. These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or

payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 80047 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89. The recommended payment is $14.89.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89. The recommended payment is $14.89.
- Procedure code 83735 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.43. 125% of this amount is $11.79. The recommended payment is $11.79.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.94. 125% of this amount is $13.68. The recommended payment is $13.68.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.94. 125% of this amount is $13.68. The recommended payment is $13.68.
- Procedure code 73520 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $25.83. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $43.85. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $43.85. This amount multiplied by 200% yields a MAR of $87.70.
- Procedure code 77002 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 72131 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This procedure code may be assigned to composite APC code 8005, for CT services without contrast; however, as no other CT services were provided, the criteria for composite payment are not met for this code. This service is paid separately and is not assigned to a composite APC. This procedure code is assigned status indicator S, which denotes a significant procedure, not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0332, which, per OPPS Addendum A, has a payment rate of $193.85. This amount multiplied by 60% yields an unadjusted labor-related amount of $116.31. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $111.20. The non-labor related portion is 40% of the APC rate or $77.54. The sum of the labor and non-labor related amounts is $188.74. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $188.74. This amount multiplied by 200% yields a MAR of $377.48.
- Per Medicare policy, procedure code 64483 may not be reported with procedure code 97003 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 64483 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $299.83. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $508.90. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $508.90. This amount multiplied by 200% yields a MAR of $1,017.80.
- Procedure code 97110 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $29.30. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $47.03. The recommended payment is $47.03.
- Procedure code 97116 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $25.93. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $41.62. The recommended payment is $41.62.
- Procedure code 97116 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $25.93. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $41.62. The recommended payment is $41.62.
- Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $71.77. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $115.21. The recommended payment is $115.21.

- Procedure code 97003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $79.11. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of $126.99. The recommended payment is $126.99.
- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This service is assigned to composite APC 8003. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 72158 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This procedure code may be assigned to composite APC code 8008, for MRI services including contrast; however, as no other MRI services were provided, the criteria for composite payment are not met for this code. This service is paid separately and is not assigned to a composite APC. This procedure code is assigned status indicator S, which denotes a significant procedure, not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0337, which, per OPPS Addendum A, has a payment rate of $533.60. This amount multiplied by 60% yields an unadjusted labor-related amount of $320.16. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $306.10. The non-labor related portion is 40% of the APC rate or $213.44. The sum of the labor and non-labor related amounts is $519.54. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $519.54. This amount multiplied by 200% yields a MAR of $1,039.08.
- Procedure code A9579 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code G0378 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This service is assigned to composite APC 8003. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 93971 has a status indicator of S, which denotes a significant procedure, not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0266, which, per OPPS Addendum A, has a payment rate of $96.28. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.77. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $55.23. The non-labor related portion is 40% of the APC rate or $38.51. The sum of the labor and non-labor related amounts is $93.74. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $93.74. This amount multiplied by 200% yields a MAR of $187.48.
- Procedure codes 99205 and G0378 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These procedure codes are assigned to composite APC code 8003, for level II extended assessment and management services. This composite

APC has a status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. Per OPPS Addendum A, APC 8003 has a payment rate of $714.33. This amount multiplied by 60% yields an unadjusted labor-related amount of $428.60. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $409.78. The non-labor related portion is 40% of the APC rate or $285.73. The sum of the labor and non-labor related amounts is $695.51. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $695.51. This amount multiplied by 200% yields a MAR of $1,391.02.

5. The total allowable reimbursement for the services in dispute is $4,549.46. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $4,549.46. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,549.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,549.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.